Older People and Public Policy Briefing – September 2016

SOCIAL CARE

Social care for older people: Home truths

The King’s Fund

This report offers a comprehensive analysis of the pressures on social care in recent years, its current state and options for the future. The report bases its findings on national data and in-depth interviews with four local authorities.

Past pressures

- Even before 2010, public support was able to meet only a proportion of older people’s care needs.
- Central government has reduced local government funding by 37% in real terms between 2010/11 and 2015/16.
- The number of older people receiving publicly funded care has dropped by 26%.
- Local authorities have reduced the fees they pay care providers to manage their budgets.
- Local authorities have tried to protect older people with the highest needs when making reductions.
- More is being asked of unpaid carers i.e. family and friends.
- Pressure on primary and community NHS services has compounded pressures in social care.

Current state of social care

- No one really knows what has happened to older people who are no longer entitled to publicly funded care. However, the human cost and financial costs on these people and their families are mounting.
- Care providers are faced with reduced incomes, workforce shortages, higher regulatory standards and the introduction of the National Living Wage.
- A total of 42% of adult social care spending is spent on older people – this spending amounted to £7.23 billion in 2014/15.
- Care providers are increasingly reliant on people who pay for their own care.
- Home care services across the country are facing critical workforce shortages. Large-scale provider collapse is a question of ‘when’ not ‘if’.
- Access to care is increasingly dependent on what people can afford and where they live – not what they need.
- The most visible effect of pressure in the health and care is the growth of delayed discharges from hospital.
The future

- The Government has not committed enough funding to avoid the gap between needs and resources widening.
- The gap between needs and resources is set to reach £2.8 billion by 2019.
- Spending on adult social care is set to fall to less than 1% of GDP by the end of this Parliament.

Options for reform

Achieve more with less – Continue working in the same way. For example pursuing personalisation of care, improve commissioning and integrate care. The report is clear that such efforts will not be enough in themselves to stop things getting worse.

A different offer – Without extra funding the Government should be ‘honest with the public about what they can expect from publicly funded services’. This would require a new and more explicit policy framework that made clear that for paying for care was primarily a personal responsibility. This framework would also need duties under the Care Act to be revisited.

Long-term reform – A care system reliant on more private spending to sustain itself will not be sufficient and create more inequalities. England is one of the few major advanced countries to not have reformed how it delivers long-term care. The Barker Commission was the latest independent commission to set out how a long-term settlement might be reached. The report concludes that:

‘a frank and open debate is needed on health and social care on a sustainable future – recognising that this will go beyond the lifetime of one Parliament. A mechanism is needed to secure cross-party consensus on some shared principles of reform’.

DEMOCRACY

Votey McVoteface: Understanding the growing turnout gap between generations
Resolution Foundation

This briefing is the second publication as part of the Resolution Foundation’s programme of work relating to its Intergenerational Commission. The Commission aims to renew the intergenerational contract. The briefing argues that the renewal of the intergenerational contract will require broad democratic participation if elected participations are to pursue it.

Findings –

In 1964 the gap in turnout between those in retirement (66-80 years old) and those people in early adulthood (21-35 years old) was 3 percentage points.

The gap between voter turnout of people of retirement age and early adulthood then grew, particularly around 2000, peaking in the 2005 General Election at 26 percentage points.
There is a concurrence between the overall fall in voter turnout and the fall in voter turnout according to age. Voter turnout for people aged 66 to 80 years old was only 2 percentage points lower in 2015 compared with 1964. However, for people aged 21 to 35 year olds the drop was 24 percentage points.

**What would be happening if voter turnout among younger adult had not fallen?**

If the relative voter turnout for people aged 35-and-under and overall voter turnout had remained constant since 1964 there would have been 1.2 million additional voters at each of the past five General Elections and voter turnout would have been 2.6 percentage points higher.

**Differences between generations of younger adults**

The research identifies a clear divergence in voter turnout amongst younger adults for the generation born between 1966 and 1980 compared with older generations of younger people. For example, voter turnout amongst younger adults born between 1911 and 1925 and younger adults born between 1966 and 1980 is as much as 20 percentage points.

**Older advantage**

The briefing reports that not only are older people more likely to vote there are also more of them giving them even more of an advantage. For example, its reports that at the 2015 General election each millennial was joined by 400,000 people born in the same year, for each member of generation X (1966-1980) this number was 485,000 and for baby-boomers (1946-1965) this number was 530,000. This could give the baby-boomer generation 33 per cent bloc boost when compared with millennial.

**Why are fewer younger people voting?**

A decline in voting when first eligible. This is a strong determinant of subsequent voting behaviour.

More younger people are renting (62% of millennials at age 28 compared to 35% of baby boomers at age 28) and renters are much less likely to vote than homeowners. The briefing speculates that home owners are more attached to their local community and therefore more likely to vote.

Younger millennials with a degree are even more likely to vote than older generations of young adults. However, the gap in voter turnout between younger adults with a degree and those without a degree has increased. For example, the gap in voter turnout in their 20s for the baby boomer generation was 15 per cent and for millennials was around 40 per cent.

The briefing reports that lower home ownership is associated with lower education attainment meaning that there is a serious risk of intra-generational democratic engagement as less-educated renters stay away from the polling booth in increasing numbers compared to their higher-educated home owning peers.
Younger generations of younger adults are less likely to identify with a political party. For example, in 1992 74% of people aged 21 to 35 years old cared ‘a great deal’ who won the General Election compared with 56% in 2015. Similarly in 1974 just 9% of this age group did not identify with any individual political party compared to 23% in 2015.

**Options**

- Mandatory first-time voting – Voters would be required only to turn out to vote with the option ‘none of the above’.
- Extending the franchise to 16 and 17 years old – School and family could help embed voting behaviour.
- Online voting
- More determined enforcement to compulsory voter registration in the UK
- Renewed citizenship education for young people

**HEALTH**

*Growing older in the UK: A series of expert-authored briefing papers on ageing and health*

*British Medical Association (BMA)*

This report brings together a series of briefing papers by external experts, published by the BMA board of science, on the health and wellbeing of people as they age in the UK. The report is part of the Association’s developing focus on the health of older people.

The report contains six briefing papers. These cover:

- Older people and the social determinants of health
- Health and social care services
- Older people’s mental health and wellbeing
- Living with long term conditions
- The perception of ageing and age discrimination
- Supporting carers

**Summary: The perception of ageing and age discrimination**

This briefing outlines perceptions about ageing in the UK and their implications for (i) health and wellbeing of us as we age (ii) health care professionals and organisations.

In 2008/09 the survey results of 2000 respondents in the UK found that people thought youth ended at 35 and old age begins at 59. People who worked in health care tended to set the beginning of old age at a later age than 59.

Research finds that in the Western world compared with younger people are likely to be stereotyped as frail, ill and dependent and having a low social status. People aged 70 and over are seen to be a ‘burden on the health service’. The media depict older people most frequently as consumers of finite resources.
Not all perceptions of older people are negative. Compared to a 25-year old a 75-year-old is more likely to be viewed as polite, good at settling arguments, understanding other people’s point of view, and having a healthy diet.

Based on the ‘stereotype content model’ comparing younger and older people along the basic dimensions of warmth and competence older people are viewed as having high warmth but no competence.

Once perceptions of age being a person’s perceptions of his or her own ability this can negatively impact health and wellbeing and influence decision making. Research in the United States has shown that people with negative perceptions of ageing are less likely to engage with preventative health behaviours e.g. eating a balanced diet. A longitudinal study of Ohio residents aged 50 and over found people with a positive view of ageing tended to live 7.5 years longer than those with more negative ones.

Further research has found that perceived everyday discrimination is associated with increased symptoms of depression, worse self-rated health, functional limitations and chronic illness.

The research suggests that health professionals make decisions and judgments about older adults that are affected by implicit ageism or age biases that devalue older people.

In a randomized control trial 121 physicians were asked to assess, diagnose and prescribe treatment for two identical patients through a case study presenting with depression. The patients were aged 39 and 81. The physicians took longer to make decisions for the older patient and were more likely to diagnose dementia and physical illness. In contrast younger patients were more likely to be diagnosed with depression and anxiety and offered more varied treatments.

**Recommendations**

Societal narratives that denote older adults as a burden on health care resources and a drain on the economy need to be challenged.

Health care professionals and organisations should be aware of the different ways ageism can happen in health and care. For example, age discrimination can occur in the interactions between health care professionals and patients.

Health care professions and organisations should be adopting practices and approaches the avoid perpetuating dependency, dehumanisation or negative age stereotypes.

Those responsible for training health care professionals should be aware of negative perceptions of age. Health care professionals should make sure that not to make a person’s age salient unnecessarily.
Quarterly Monitoring Report: September 2016
The King’s Fund

The latest reporting from the King’s Fund gives a comprehensive picture of the state of NHS finances and quality of performance. The report is written in the context of the NHS’s Sustainability and Transformation Plans first announced in December 2015 and due for approval this Autumn. This is the first reporting since the EU referendum.

Sustainability and Transformation Plans (STPs)

After experiencing its highest ever overspend last year the NHS has created a Sustainability and Transformation Fund worth £1.8 billion. This money will be paid out to NHS providers in deficit but only where they meet a set of finance and performance targets. Despite the fund NHS Improvement already expects a £250 million deficit this financial year. If providers fail to meet the financial and performance requirements required of them access to the STPs will be withheld.

Financial performance

Providers: Despite the STPs nearly half (47%) of NHS providers are forecasting deficits this year. This will leave trusts entering 2017-18 with an underlying deficit. A total of 40% of NHS providers are ‘concerned’ or ‘very concerned’ that they will not hit their financial targets in 2016-17.

Commissioners: In 2015-16 NHS commissioners underspent their budget by £670 million. Compared to this time last year the percentage of commissioners expecting a deficit or to break-even has risen from 24% to 43%. Moreover the number ‘concerned’ or ‘very concerned’ about meeting their savings targets has risen from under 30% to more than 60%.

Reducing reliance of agency staff

A total of 70% of organisations expect to reduce their use of agency staff. This is a common objective across the acute, community and mental health sectors.

Quality of care

- More than half of respondents (from NHS trusts and CCGs) think patient care has declined over the past 12 months. Delayed transfers of care and the four-hour A&E target were the top concerns for trusts and CCGs respectively.
- Days lost to delayed transfers of care have risen by 23% since June last year.
- In Quarter 1 2016-17 the proportion of patients waiting more than four hours from arrival to discharge, admission or transfer.
- The proportion of patients still waiting to be seen 18 weeks after referral increased in June 2016 to 8.5%. The target is that a maximum of 8% experience a wait of more than 18 weeks.
- The proportion of patients still waiting to start cancer treatment more than 62 days improved slightly compared to the last quarter to 17.6%. The target is that no more than 15% of patients should wait more than 62
days from an urgent referral from their GP to receiving treatment for their cancer. This standard has not been met for the past two and a half years.

- The proportion of patients waiting more than four hours from arrival to discharge, admission or transfer in all A&E departments was 9.7% in Quarter 1. This is the highest level in the first quarter of the year since 2003/4. Compared to the same quarter last year A&E attendances were up 2.8 per cent and emergency hospital admissions from A&E increased by 4.2 per cent.

**The longer term future**

Over half of financial directors in both NHS trusts (64%) and CCGs (55%) are ‘fairly’ or ‘very worried’ about achieving financial balance in 2017/18. This pessimism intensifies looking further forward with 77% of trusts and 70% of CCGs reporting a high or very high risk the NHS will not deliver the efficiency savings needed as part of the NHS Five Year Forward View.